

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038716

DO NOT WRITE
ON THIS SUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5194

STATE FILE NUMBER

FILED OCT 25 1962

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN PRAIRIE VILLAGE	
Length of stay in 1b 4 MONTHS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3522 WALNUT STREET WALNUT NURSING HOME		d. STREET ADDRESS (If outside, give location) 6742 FONTANA	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE GLADICS		4. DATE OF DEATH Month OCTOBER Day 11 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN
9. AGE (last birthday) 81		10. BIRTHPLACE (City and state or country) HUNGARY U. S. A.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OF WIFE JOHN GLADICS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. ---		17. INFORMANT STEVE GLADICS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>6-29-62</u> to <u>10-11-62</u> and last saw her alive on <u>9-30-62</u> . Death occurred at <u>3:05 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Philip D. Reister M.D.</u>		22b. ADDRESS <u>518 Argyle Bldg.</u>	
22c. DATE SIGNED <u>10/14/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>10-13-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOVELAND COLORADO</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		25. DATE RECD. BY LOCAL REG. <u>10-13-62</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Philip D. Reister

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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Ch. Wallace H. Graham
518 Apple Rd.
12.00 - 14.00

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Louis Duane

Licensed Embalmer No. 4096

P.O. Address K.E. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.